

# Montgomery County Dependent Daycare Reimbursement Claim Form



If Faxing  
# of Pages: \_\_\_\_\_

## EMPLOYEE INFORMATION *(Please Print)*

Check here if address has changed

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

SSN: \_\_\_\_\_  
Email : \_\_\_\_\_  
Day Phone: \_\_\_\_\_

### \*\*IMPORTANT NOTE\*\*

The following series of check boxes *must be checked* or your claim will not be processed. By checking the boxes you certify the information to be true and accurate to the best of your knowledge.

My claimed dependents are: (check all that apply)

- Under the age of 13
- Disabled in need of supervision
- Elderly in need of supervision

Check one of the following:

- I am Single (\$5000 max election)
- I am Head of Household (\$5000 max election)
- I am Married filing separately and my spouse is gainfully employed (\$2500 max election)
- I am Married filing jointly and my spouse is gainfully employed (\$5000 max election)

I also certify: (check all boxes)

- Expenses are not for K-12 school tuition
- The daycare provider is not my spouse or underage child
- My claimed dependents reside in my household the majority of the year

## Dependent Daycare Expenses

*Supporting documentation is required only if provider does not sign this form. Otherwise, documentation must include the provider's name, address, Tax I.D.#, dates of service and amount charged.*

Child's Name	Age	Service Date		Name & Address of Service Provider	Amount
		From	To		
<b>Total Unreimbursed Daycare Expenses</b>					

I certify that I have provided dependent care as described above. I have charged \$\_\_\_\_\_ for the services I rendered on the dates listed above and it is not for tuition expenses associated with Grades K-12.

Provider Social Security # or Taxpayer ID # \_\_\_\_\_  
Title \_\_\_\_\_

Signature of Dependent Care Provider \_\_\_\_\_  
Printed Name \_\_\_\_\_

## READ CAREFULLY AND CHECK EACH BOX

- The above is a true and accurate statement of all expenses incurred on the dates indicated, and were incurred while I was covered under the Dependent Daycare Flexible Spending Account.
- Supporting documentation from my service provider for all expenses is attached to this voucher or the provider has verified the expense with their signature and tax information.
- I understand that I cannot claim any reimbursed expenses on my income tax return.
- I understand I may be liable for payment of all related taxes including Federal, State, or City income tax on the amounts reimbursed for any expense improperly claimed under the provisions of the Dependent Daycare Flexible Spending Account.

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

**Mail To:** myCafeteriaPlan, 432 East Pearl St., Miamisburg, OH 45342  
**Fax To:** 937.865.6502      **Email To:** claims@myCafeteriaPlan.com

Access your account information 24 hours a day, seven days a week on our web site: [www.myCafeteriaPlan.com](http://www.myCafeteriaPlan.com)